



Ankle & Foot Specialists of Puget Sound, P.S.
Patient Information Form

Date: ____/____/____

Patient Name: _____ (Last) _____ (First) _____ (MI) M F

Date of Birth: ____/____/____ Age: _____ Social Security: ____-____-____

Mailing Address: _____ Apt/Unit#: _____

City: _____ State: _____ Zip: _____

Primary Phone: (____) _____ Home Cell Work **Leave Message?** Yes No

Secondary: (____) _____ Home Cell Work **Leave Message?** Yes No

Email: _____

Responsible Party: _____ (Last) _____ (First) _____ (MI) M F
 (↑ ONLY FOR MINORS)

Date of Birth: ____/____/____

Student Retired Other Employed at: _____

• **Primary Care Doctor:** _____ **I HAVE NO PRIMARY CARE DR**

• **Office Name:** _____ **City:** _____

• **Emergency Contact:** _____ **Phone Number:** _____

• **Relationship to Patient:** _____

Primary Insurance: _____ ID#: _____ Grp# _____

Name of Subscriber: _____ Relation to Patient: _____

Subscribers DOB: _____ Employer: _____

Secondary Insurance: _____ ID#: _____ Grp# _____

Name of Subscriber: _____ Relation to Patient: _____

Subscribers DOB: _____ Employer: _____

Is this visit **Injury Related?** _____ Date of Injury: _____ Work/Auto/Other: _____

Employer at time of injury: _____ Claim #: _____

Claim Manager: _____ Phone Number: _____

I consent for medical treatment and I have verified the insurance listed on this form is accurate. I authorize my insurance benefits be paid directly to Ankle & Foot Specialists of Puget Sound. I am financially responsible for all/any patient responsibility. I authorize the Physician/Facility or the Insurance Company to release any information required for this claim to be processed. We are a fee for service provider for all medical care received. I may be charged a \$25.00 No Show Fee if 24 hour notice is not given.

Signature: _____ **Date:** _____

Relationship (if minor): _____